

Washington State Employee Assistance Program (EAP) Contracted Provider Invoice

Do not include any protected health information on this form. This is a billing form and the EAP referral number is required to receive reimbursement.

Provider's Name:

Make Check Payable To:

Mailing Address:

Phone Number:

Provider's EAP Contract Number:

EAP Referral Number (required):

Date of Service	Service Rendered	Time Spent

Provider Signature: _____ Credentials: _____ Date: _____

Submit this invoice along with all assessment forms to:

Department of Personnel
Employee Assistance Program
Attn: Contract Manager
701 Dexter Avenue N, Suite 108
Seattle, WA 98109
206-281-6315
Fax 206-281-6319



WSD Personnel Washington State
Employee
Assistance
Program

DOP 12-032 (4/22/08) EAP Contracted Provider Invoice